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Working Hard for the Ones You Love and Care for under Covid-19 Physical Distancing

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Abstract

In 2020, Covid-19 was spreading quickly in nursing homes, leading to numerous challenges for care workers. We tell the story of Marieke, a devoted female care assistant working in a Belgian nursing home that is customer-centred in their organisational model. Her narrative provides poignant insights into the 'work and life' struggles and conflicts of a female care assistant facing the challenges of this model during the Covid-19 pandemic, which has left the largely female care workforce widely exposed to the risk of work intensification and over-involvement with residents, especially in a context of liberalisation and privatisation of care. In the early stages of the Covid-19 pandemic, this model led to Marieke facing the unprecedented fear of endangering her own life and the lives of those she loves. In this article, she reflects on her work and family life under the strain of ensuring physical distancing in a nursing home.

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Introduction

This article tells the narrative of a Belgian care worker employed in a nursing home in the first wave of the Covid-19 pandemic (March – June 2020). Although Belgium, like its neighbouring countries, was in a strict lockdown during this period (including compulsory working from home, online teaching and restrictions in movements), the virus heavily hit and circulated across different nursing homes (Barnett and Grabowski, 2020). The virus aggressively spread among people with chronic conditions – typically nursing home residents (Barnett and Grabowski, 2020). Therefore, it is in the nursing homes where the majority of Covid-19 deaths occurred (Adalja et al., 2020). This was also the case in Belgium, which reported the highest number of deaths per 100,000 inhabitants worldwide; 66% of these deaths were in nursing homes.

The Covid-19 pandemic had major consequences for how nursing home workers experienced work and life, and accentuated previous working life issues (e.g. Armstrong et al., 2020). Even before the Covid-19 outbreak, many care workers in elderly care faced multiple working life issues, often being employed with unstable job contracts under highly demanding working conditions (Clarke, 2015). Liberalisation and privatisation, namely, have profoundly changed care provision in Europe, with public monopolies abandoned in favour of markets and competition (Hermann and Flecker, 2012). Within social care, a system of market mechanisms has been introduced, resulting in a deterioration of employment and working conditions (Burns et al., 2016). Studies examining the spread of Covid-19 in nursing homes point to measures related to profit maximisation, such as reduced staffing numbers (Armstrong et al., 2020).

Scholarly work demonstrates that these changes also lead to contrasting pressures in the care sector of cost minimisation and delivering high service quality (Harley et al., 2010; Korczynski et al., 2000). In nursing homes, the latter has led to the introduction of a customer-centred organisational model (Lopez, 2006; Verbeek et al., 2009), a ‘caring’ model increasingly present in private and public nursing homes, where a ‘homelike’ care environment allows residents to live a life closely resembling their previous everyday life (Vermeerbergen et al., 2017). Although the benefits for residents are often sketched (Verbeek et al., 2009), whether a customer-centred model also improves working conditions in nursing homes is debatable (Lopez, 2006), especially as the new ‘caring’ model means that care workers become physically and emotionally more attached to residents (Vermeerbergen et al., 2021). The worker–customer relationship is a special one, consisting of a mix of worker ‘duties’ covering both the job and the ‘moral’ responsibilities involved in catering to residents’ physical and emotional needs (Verbeek et al., 2009). We contend that this profoundly impacted the working conditions of care workers in the midst of the Covid-19 pandemic, with important implications for the reconciliation (or ‘articulation’; see Smith and McBride, 2020) of work and life, as contextualised by Marieke’s narrative in Belgium.

The article illustrates the consequences of the customer-centred care model and its implications for the ‘work and life’ of workers during the Covid-19 pandemic when the

increase in workload (Armstrong et al., 2020) had left care workers highly exposed to the difficulty of combining domestic and professional care duties. This model profoundly reorganises care work, leaving the workforce widely exposed to work intensification. Sociological research into work–life balance speaks of intensification and extensification in the coordination of social reproduction tasks (e.g. Rubery et al., 2005). This is especially true for care work in this customer-centred model where a predominantly female workforce faces the challenge of reconciling the intensification of professional work with care duties at home (Crompton, 2006).

During the first wave, we conducted two online interviews with Marieke, a care worker in a customer-centred nursing home in the Flemish Region of Belgium. Marieke's narrative provides poignant insights into the 'boundary work' struggles she faced when having to decide whom to care for most during the Covid-19 pandemic: her family at home or nursing home residents. It became impossible for her to care for everyone, as the lack of physical distance at work meant endangering the lives of her loved ones at home. To contextualise Marieke's story within existing literature, we first briefly present the implications of the customer-centred organisational model for carers, embedding this in notions of work–life articulation. A brief presentation of the methodology used is followed by Marieke's narrative.

The customer-centred organisational model in social care: Solution or trap for workers?

Residents in nursing homes show increasing personal care demands, translating into more customer-oriented care needs. When expectations are not met, residents find it easier to voice complaints (Leventhal, 2008) or even to search for 'alternative' housing solutions (e.g. cooperative care associations; Leviten-Reid and Hoyt, 2009). To survive, nursing homes are being forced to provide better care with many having introduced a new organisational model – 'the customer-centred care model' – aimed at meeting customer demands (Verbeek et al., 2009). Importantly, this has been happening in a sector where costs have been cut and where privatisation has led to a growing finalisation of care (Burns et al., 2016). Therefore, this model resembles, in practice, a customer-oriented bureaucracy (Korczynski, 2002) where the dual logic of achieving high service quality in a context of customer control is combined with making profits. Korczynski (2002: 80) outlined how this hugely impacts the way workers deliver services: '[m]anagement must somehow create a fragile social order that promotes sufficient efficient and customer-oriented behaviour from front-line workers to ensure the creation of a profit'. This is especially relevant for elderly care, a sector characterised by close interactions between customers and care workers (Harley et al., 2010).

The customer-centred care model has been implemented across nursing homes. First adopted in the 1970s in a wide range of Scandinavian care institutions, the model spread to nursing homes worldwide (Verbeek et al., 2009). Under it, residents can lead lives similar to those they had before they moved to the care facility. They have ample say in what their daily activities are and how these are organised. The creation of small units where six to 15 residents live facilitates the creation of a 'homelike feeling' (Verbeek

et al., 2009). Care workers usually provide both medical care, such as giving injections, and personal care, such as helping with the cooking.

Realising this model in an era of liberalisation and privatisation creates conflicts between cost reduction practices and customer-oriented behaviour, which induces debatable consequences for care workers. While Clarke (2015) emphasised that elderly care workers 'loved the work because they were able to "make a difference"', there is a constant danger in this model of workers becoming emotionally over-involved due to the close relationship with residents (Vermeerbergen et al., 2021) in a financial constraining care setting. Moreover, they are supposed to provide customised 'high-quality' care, an obligation which translates into broader care and personal tasks (Vermeerbergen et al., 2021). This may become difficult for carers, especially as care work does not stop upon clocking out (Beauregard and Lup, 2020) and is intensified because of cutbacks, leading to fewer staff hours (Burns et al., 2016). The temporal intensification of work thus goes along with the spatial extensification of work, blurring the boundaries between work and life and causing 'overflow' between inside and outside the workplace (Pratt and Jarvis, 2006). Increasingly, care workers have to find their own ways of navigating between care responsibilities at work and family responsibilities at home.

Marieke's narrative clearly illustrates these challenges and the personal risks she faces in the customer-centred care model as implemented in Belgium. In particular, her narrative shows how the health crisis triggered by Covid-19 exposed a largely female workforce to the disruptive consequences of an organisational model which cares less for workers than for customers due to its dual logic of profit maximisation and high service quality.

Meeting Marieke

We got in touch with Marieke via the trade unions. Our contact person gave us Marieke's details after we explained that we were interested in interviewing female care workers who have family responsibilities and work in customer-centred nursing homes affected by Covid-19. Marieke is a union representative in such a nursing home. We initially contacted her via e-mail, explaining that we wanted to write an article together with her about a female care worker's experiences during the pandemic. Marieke was very enthusiastic about the project.

We met Marieke twice, via Skype and Zoom, on 7 May and again on 8 June (in the midst of the first wave of the pandemic in Belgium). We also had phone calls and WhatsApp chats with her. Between 1 March and the first interview, 8374 people died of Covid-19 in Belgium, making it the country with the highest number of deaths per 100,000 inhabitants.

The first time we met Marieke on Skype, we used a modified version of the autobiographical narrative interview method of Fritz Schütze (2008). We asked Marieke to tell us about her work experiences: how her working life had developed against the backdrop of her life history. We followed up the uninterrupted narrative part by questions concerning the narrative itself and particular aspects of her work situation. Marieke was given time and space to tell us in her own words what she was going through, describing in great detail what emotions and reflections it evoked. After transcription and analysis, we

met Marieke to ask additional questions. We then wrote down Marieke's story with her active involvement. A first draft was written by the researchers, with Marieke then asked for examples and further elaboration. The completed article was sent to Marieke, who translated the text with the help of her husband and Google Translate. She rewrote a few paragraphs and made notes asking for changes and additions. This was accompanied by discussions in Dutch, her mother tongue. Following several interactions between researchers and Marieke, the final article is the one that both Marieke and the researchers agreed on.

Marieke's story

Caring under the dual logic of rationalisation and service quality

Nearing the end of high school and before graduating, I started working in care. As a child it had already been my calling to take care of the elderly. I really felt it when my primary school organised a day where all pupils were sent out to take part in day-to-day working life. Some of my friends chose, for instance, to spend the day as cashiers in a supermarket. I chose to help out in a nursing home. Ever since then, I kept on telling myself, 'that's something I want to do'. Now 34, I am still working in elderly care.

I've found a job in my hometown as a care assistant in a nursing home where I take care of people with dementia. Not regretting my choice to work in care for a second, I love my job. The love and the respect I receive from *my* residents is a feeling I cannot fully describe. Even though many residents are no longer able to speak, it's that look in their eyes and their gratitude. That's why I became a care worker.

However, I have to confess that two years ago I really considered quitting this job. There were cutbacks and management said that the number of care hours needed to be reduced. We had to become more competitive. I thought, how will we manage to take care of residents with fewer care workers? I now have to wash 15 residents with dementia (in two units) in just a couple of hours. That's possible, but the quality is much lower. But I want to provide high quality. I want to enter and leave the nursing home with a smile. And more importantly, I want to see the residents smile as well. When I look back at the last 17 years, I get the feeling that my workload has increased a lot. I used to get back home less physically and psychologically tired. Nowadays, I just say to my kids: 'Guys, just leave me alone for half an hour'.

Besides the cutbacks, the price of living in this nursing home has increased over the years. It now costs about 2000 euros a month, with medicines not even included. As a result, many elderly people only start living here at an advanced stage of their illness. Previously, half of residents could still walk, but now the ones who can still walk or wash themselves are an exception. The physical side of the work has thus increased enormously, making the job very demanding. And quality has gone down the drain.

Working in a customer-centred nursing home

I work in two small, interconnected living units, each for eight residents, located across a hallway. Residents do not move between units.

I strongly believe that as a care worker you can give better care in a small-scale setting. The residents feel more at home and as a care worker I know their individual needs. That is very much different from a more traditional nursing home, where you take care of far more residents and thus don't know them that well. The way caregiving is organised here makes it feel like your grandmother or grandfather is living in your own home. This means I do far more different tasks than my colleagues in other nursing homes. As a care assistant, I go for walks with the residents and make soup with them. We do crossword puzzles and the laundry together. I like this variety of tasks, but sometimes so many things add up that I simply don't know when everything can be done. On top of that, management has cut the number of hours per resident.

I am very committed, as the living unit is my second home. I come 'home' when I start working; and when I leave, I go from one home to my other one. The residents feel like my second family. We eat together and I tell them everything about my children, what has happened at school and what we have done at home. I am also very close with residents' families, most of whom I know personally. You can put this down to the small-scale setting: as caregivers, we are accessible for residents and their families alike. Taking care of the same group of residents, day in, day out, creates a strong bond.

However, this strong relationship is sometimes a psychological burden, especially when residents get sick or when they die. I am really bad at putting emotional distance between myself and the residents. I don't know how other care workers manage to do it.

The Covid-19 outbreak: Work intensification and emotional over-involvement

In my living unit, just one resident got infected. There was, however, a major outbreak in the nursing home, with 17 residents becoming infected in May. Some of them died, four within 24 hours. This was really exceptional and dramatic, especially as usually just one resident dies every couple of months! My colleagues and I were thinking, 'What's going on? We're losing them all!' Emotionally, it was very difficult.

During the outbreak, my work intensified. Before, it was already difficult to perform all care and personal tasks in the nursing home. Now, I need to do so much more that I wonder how I manage to do it all.

There are, for instance, new safety rules. I have washed so many hands these last few weeks. Before dinner, I have to go to all residents, one by one, to wash, disinfect and dry their hands. I have to help them with this, otherwise they might end up putting the disinfectant gel in their hair. All residents I take care of have dementia, so they don't understand what is happening. I wash their hands and bring them to the table, making sure they don't touch anything. That takes at least 20 minutes. After the meal, I have to wash their hands again. I spend 40 minutes just washing hands for one meal only. But there are three meals a day, plus coffee breaks.

I'm also responsible for the facemasks in the unit. I put them on residents, but those with dementia keep taking them off. They touch their faces, thinking 'what's this?'. In addition, when a resident comes back from hospital, I have to put on a protective suit. Hospitals are a breeding ground for the virus, meaning that when residents get back from

there they have to be quarantined in their rooms for two weeks. I have to wear a protective suit before entering. It takes 10 minutes to put it on, and 10 minutes to take it off. But when you turn your back, residents with dementia will already be out in the hallway. I then have to take them back to their rooms. It's such an effort. And I have to do all of this by myself.

Another extra task during Covid-19 are the Skype calls with families. As they're not allowed into the nursing home, they want to have a video call and I'm expected to set it up. Before the outbreak, family members could come and go whenever they wished.

All these new tasks come on top of my normal work duties. I work alone in the unit because of the way we are structured here. This means I can't pass anything on to a colleague. There is also no additional support because of Covid-19. Ironically, now I don't even have the help of family carers. And others, like cooking, cleaning and admin staff, are helping less than before. While the latter enter my living unit less to avoid contamination within the nursing home, volunteers from outside are not present at all, again to avoid infection. While I understand this, it all adds up to many more things on top of my normal work.

In the last few weeks, I've had to give up many work routines, a factor further increasing my workload. Now, I have to think 10 times about everything I do, constantly assessing the risk. For instance, when residents want something to drink, I have to think, 'Oh yes, the facemask needs to be taken off'. Residents are also not supposed to touch each other's spoon, fork or cup. And the 1.5-metre distancing rule is a true routine-breaker. It's impossible to stay 1.5 metres away from my residents, especially in this homelike care setting. When residents cry, I normally give them a hug. I help residents in bed. I could do this the cold way: 'Here's your blanket, do it yourself'. In such situations, I don't follow the 1.5-metre rule. I still hug and help residents in bed – it would be inhumane not to do so. This is my second family; I really care for them.

Another work routine that has changed is that an even larger part of my job involves making sure that the homelike atmosphere is maintained, with everyone feeling at ease. Many residents get afraid and worked up when they hear on television that there is a war going on. Especially residents with dementia, [who] panic again and again when they hear the news. Or, when a resident says, 'My daughter is going to visit me', I have to say, 'Well, your daughter won't be coming'. People get really nervous. When residents get worked up, I try to separate them from the group for a while, otherwise their agitation might spread to other residents, leading to even more work.

Besides this increased workload, I also felt that my emotions were like a rollercoaster during the Covid-19 outbreak, going from feeling powerless, scared, angry, to being happy. The living unit is my second home. This has made the last weeks difficult because when residents get sick, it's like a family member getting sick. Covid-19 has shown me how much I care for my residents.

When the results of Covid-19 tests are reported (by the government), it is always a bit scary. Last week I got very angry after seeing the results. One resident who had tested negative for Covid-19 had a nasty fall in the living unit and had to go to the hospital for surgery. When she came back, she tested positive. I had followed all instructions very carefully, but then she got infected in the hospital. I thought, 'If I can avoid infections in a nursing home, why can't they manage to do so in a hospital!'. That is so frustrating and

surreal. I watched her getting worse; she couldn't even eat anymore. A lack of oxygen is so painful. But yesterday she came back to the unit after her quarantine. I saw her walking around and laughing. It made me feel so happy.

I often feel helpless. Residents' emotions really hurt me. It hurts, for example, to see my residents unhappy due to the measures taken to prevent the spread of the virus. I get a lot of satisfaction from taking care of my residents, but I can't do everything. There is just not enough staff to take good care of the residents. That's hard.

Physical distancing and the need for work–family (re)articulation

I've got two kids (10 and 11 years old), a good husband and my parents are still alive. My work in the nursing home with Covid-19 cases has led to heated discussions with my kids and husband, impacting my work in the nursing home and at home.

At the beginning of the pandemic, when the first case was detected in the nursing home, my husband said: 'You'll have to stop working there. You'll make us all sick.' I said: 'No, I can't do that. This is my job, my heart's in it. I just love caring for sick people.' Then he said: 'You need to stay at home because you suffer from asthma and you've got a weak wrist'. My husband is also worried because he has chronic obstructive pulmonary disease. His reasoning is thus perfectly understandable, but I cannot do that. I love taking care of people. I can't handle it differently. I want to be with my colleagues, saying, 'Come on, let's go for it, we're going to ensure everything will be OK'.

I was able to convince him by arguing that I really love these people and don't want to leave them. If I don't go to work and other colleagues do the same, the residents will be left alone. A new care worker would then come, someone they don't know. I can't do that, because the nursing home is my second home, the residents my second family. That was really hard for my husband to understand. 'How is that possible? It's just work.' He works for a chemical company, a totally different business. Then I said that it would basically be like not coming home anymore or not getting to see the children, as they were at school and might get infected. I also spoke of his dad who lives in another nursing home: 'Imagine the care workers not showing up where your dad lives. The new care workers wouldn't know what he is like. He would be all alone.' That helped him understand.

Really scared, my kids asked me several times: 'Why do you have to go to work?'. I tried to explain to them why I kept working in the nursing home in the same way I explained it to my husband. But they didn't cotton on. They said: 'Imagine the residents get sick, then we get sick too'. I said that they were just kids and that the chance of them getting sick was very small. I said: 'Mama takes a shower at work and one at home, mama wears protection at work, mama washes her hands and has bought disinfecting gel for in the car'. They finally agreed, but I had to promise not to work more hours than I normally do when residents get sick. Each day when I get home from work, I have to report to them what I've done and whether any people have got infected or recovered.

Because of these discussions, I do my very best to follow all instructions to avoid the spread of Covid-19, but what I can't do is to stop working in my living unit. I understand that, for them, it seems as if the entire nursing home is full of the virus. That is also what they hear on the radio and television. That is, of course, not the case, but this perception

leads to tensions at home. If I don't wash my hands straight away, they immediately say: 'Wash your hands, think about us'.

But it's not only them. I'm afraid as well. I live in fear all the time. I don't want to get infected, but more importantly, I don't want to infect others. I often get tested. These are difficult times, because I'd feel very guilty if I got infected. At the beginning of each shift in the nursing home I feel a bit stressed because I could get infected, and then infect my family as well. I'd feel very guilty if I brought it home. I do everything to avoid contamination, but it can always happen, of course.

Alongside the discussions, my changed work situation has had a big impact on my duties at home, with Covid-19 making it difficult for me to continue doing my household chores. Before, I used to do a lot more housework. I now do a lot less cleaning because my job is so exhausting. When I'm home with my family, I tell myself, 'I'll do the cleaning later. As long as the table is clean, I can mop over the floor next week.' After a full working day, I just have no energy left.

It is not that I'm just tired after work. My residents are also on my mind all the time. When I'm at home, I'm constantly thinking about my second family. Before the outbreak, it was easier to close the door, leave work behind. Now, I can't do that. This has its consequences, especially because Covid-19 has led to further chores: for instance, I have to wash my clothes separately. I'm the one in the family who does the shopping (also for our parents and neighbours in quarantine). The primary school is running online at the moment, meaning that I and my husband have to help our kids with their homework. All this additional work at home and in the nursing home is driving me nuts. I feel I'm working non-stop in the living unit and at home. I'm busy all the time. It's been like this for 12 weeks now (June 2020). Already very hard before the pandemic, the work has now become just impossible.

I have nightmares about my work in the nursing home and at home. I have bad dreams about passing on the virus to my kids, husband or residents after forgetting to wash my hands. I often wake up in the middle of the night bathed in sweat and the following morning I am worried about what can happen to those I care for today.

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